

Mail completed copy to:

Department of Labor and Industry
Claims Services and Investigations
PO Box 64229
St. Paul, MN 55164-0229
(651) 284-5045 or
1-800-342-5354 (DIAL-DLI)
Fax: (651) 284-5733

Notice of Intention to Claim Reimbursement From the Second Injury Fund

PRINT IN INK or TYPE your responses
All dates must be entered in MM/DD/YYYY



DO NOT USE THIS SPACE

WID or SSN	DATE OF INJURY
EMPLOYEE NAME	INSURER/SELF-INSURER
EMPLOYER NAME	INSURER/ ADDRESS
INSURER CLAIM NUMBER	CITY STATE ZIP CODE

ATTACH COPY OF ACCEPTED REGISTRATION OR DOCUMENTATION OF AUTOMATIC REGISTRATION

1. Nature of registered condition	2. Dates of previous work-related injuries, if any
3. Nature of subsequent injury causing disability for which reimbursement is being claimed	
4. The insurer is claiming that this disability is (check one): a. <input type="checkbox"/> more serious because of the registered condition (substantially greater) M.S. § 176.131, subd. 1. b. <input type="checkbox"/> caused by the registered condition (except for) M.S. § 176.131, subd. 2.	

ATTACH MEDICAL REPORTS TO SUPPORT THE ITEM CHECKED ABOVE COMPLETE THE REHABILITATION AND WORK STATUS REPORT ON THE BACK OF THIS FORM

Name of Preparer	Date
TPA Name	Phone No. (include area code & ext.)
Address	

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

CLAIMS SERVICES AND INVESTIGATIONS OFFICE USE ONLY

Claim APPROVED on _____ by _____	
Deductibles <input type="checkbox"/> 26 weeks and \$1,000	<input type="checkbox"/> 52 weeks and \$2,000; apportionment under M.S. § 176.131, subd. 1(a)
<input type="checkbox"/> 52 weeks and \$2,000	<input type="checkbox"/> No deductibles
Other: _____	
Claim REJECTED on _____ by _____	
Deductibles <input type="checkbox"/> No Registration found	<input type="checkbox"/> Documentation of automatic registration not attached
<input type="checkbox"/> Notice was filed late	<input type="checkbox"/> Medical reports to support claim not attached
Other: _____	

VOCATIONAL REHABILITATION AND WORK STATUS REPORT

1. Has the employee returned to work? ☐ Yes ☐ No

Do temporary partial benefits continue to be paid? ☐ Yes ☐ No

2. Has this case been referred for vocational rehabilitation?

☐ Yes (Complete #3)

☐ No

Reason:

☐ Disability Status Report filed requesting rehabilitation waiver

3. Current status (check **ALL** that apply):

☐ a. Plan in progress, R-2 submitted

☐ b. On-The-Job Training Plan approved and in progress

☐ c. Retraining approved and in progress

☐ d. Rehabilitation closed, R-8 submitted (check one below):

☐ 1. Employee returned to work

☐ 2. Employee retired

☐ 3. Employee died

☐ 4. Rehabilitation discontinued by settlement, mediation, arbitration or order

☐ 5. Other

Explain: